STATES OF JERSEY

Health, Social Security and Housing
Health White Paper Review

TUESDAY, 3rd JULY 2012

Panel:
Deputy K.L. Moore of St. Peter (Chairman)
Deputy J.A. Hilton of St. Helier
Deputy J.G. Reed of St. Ouen
Mr. M. Gleeson (Panel Adviser)

Witnesses:
Deputy A.E. Pryke of Trinity (The Minister for Health and Social Services)
Connétable J.M. Refault of St. Peter (Assistant Minister for Health)
Ms. J. Garbutt (Chief Executive Officer, Health and Social Services)
Mr. J. Turner (Director of Finance and Information, Health Department)
Ms. R. Williams (Director of System Redesign and Delivery, Health and Social Services)

Also present:
Ms. K. Boydens (Scrutiny Officer)

[14:32]

Deputy K.L. Moore of St. Peter (Chairman):

There are a few housekeeping issues that I have to go through quickly. Members of the public, be aware that the rules, the code of behaviour is on the wall. I think you are familiar with all of the things we ask of you, not to interfere with the public and use taping materials, and at the close of the meeting if people leave promptly we would be grateful and appreciate that. Welcome to everybody. We will start by introducing ourselves. I am Kristina Moore, the Chairman of the panel.

Deputy J.G. Reed of St. Ouen:

I am James Reed, panel member.

Mr. M. Gleeson (Panel Adviser):

I am Michael Gleeson, adviser to the panel.

Deputy J.A. Hilton of St. Helier:

I am Deputy Jackie Hilton, Vice Chairman of this panel.

Ms. K. Boydens (Scrutiny Officer):

Kellie Boydens, Scrutiny Officer.

Director of Finance and Information:

Jason Turner, Finance Director at the Health Department.

Director of System Redesign and Delivery:

Rachel Williams, Director of System Redesign and Delivery at Health and Social Services.

The Minister for Health and Social Services:

Deputy Anne Pryke, Minister for Health and Social Services.

Chief Executive Officer:

Julie Garbutt, Chief Executive Officer for Health and Social Services.

Assistant Minister for Health:

Constable John Refault, Assistant Health Minister.

The Deputy of St. Peter:

Thank you very much for joining us today. I thought it would be a good place to start to talk about the consultation process so far and what your feeling is of the public response and the public engagement. It seems to have been quite different, the engagement with regard to the White Paper in comparison to the Green. I do not know if you would agree with that.

The Minister for Health and Social Services:

Thank you very much and it is good to have this opportunity to come and speak to you about the White Paper. As you know, this is a follow-up to all

the consultation that we did on the Green Paper because we acutely realised that Health and Social Services cannot stay where it is. We need to change due to the ageing population, sub-specialisation of staff, et cetera. The consultation this time I think has been very positive. The public hearings, the one at Trinity I thought was quite vibrant and quite challenging and there was a good discussion. The one at Les Quennevais perhaps not so much so because it veered on to people's private and personal issues, so that is always difficult. But besides this, which perhaps the public do not quite realise too, is that Rachel and Louise and Tara, and me to a certain extent, have been out very much being proactive and doing quite a few focus groups. We have been to Mind, Alzheimer's, the sixth form of J.C.G. (Jersey College for Girls) as well as having a shop in town for the weekend, as well as during the week at lunchtime, handing out pamphlets and whatever. I think to date the actual number of people that Rachel has had face-to-face contact with is well over 400 people so from that point of view it has been a slightly different angle but it has been a very good angle.

The Deputy of St. Peter:

Have you received many written submissions?

The Minister for Health and Social Services:

Handwritten submissions, I cannot remember the last figures but not an enormous amount, but we have had over 1,200 hits on the website and we have had to do a reprint of the White Paper itself. I think the first reprint was 3,000 and there is another 1,000 that we have had reprinted. We are very much aware that the public were consulted on the Green Paper and they thought: "Well, that is it. We have done it. We have heard what you have got to say. We have said our bit." So sometimes it is difficult to keep that imagination with the public and Rachel has done an awful lot of work going with focus groups and I am sure that is going to be very beneficial.

The Deputy of St. Peter:

Generally you feel that the public perception is positive?

The Minister for Health and Social Services:

I think so. I have read the feedback that we have had already and most of it has been very positive. They pick up a few examples such as: "Where are you are going to get all your nurses from? Perhaps not so much money going into mental health", so there are particular areas that they have picked on, pointed on to, but generally the theme that is coming through is good, it is: "Let us go ahead and do it."

Deputy J.A. Hilton:

Can I just ask you a question about the age group that responded to the consultation. I noticed in the table in the White Paper that we have here that the over 65s were the age group that responded least to the consultation as compared to the 45 to 54 year-old age group who were the ones who submitted the most responses. Do you feel that you did enough work in targeting the over 65s for this consultation? Are you satisfied that you did as much as you could possibly do to try and get their responses?

The Minister for Health and Social Services:

I think it is like everything else, it is always a balance and we did do quite a few focus groups. I think we went to Age Concern and a few other places for the Green Paper. But it was felt important that we need the younger age group because they will be the ones coming through who are going to be needing that healthcare, but more importantly they are going to be the ones that are going to be paying for it with their taxes so it is important that we have got the whole range.

Deputy J.A. Hilton:

As far as you are concerned, you are satisfied you have got a broad range of responses?

Chief Executive Officer:

Rachel may want to say more but the distribution of the responses is as much as the distribution of the population, so obviously we have more younger people than older people, for obvious reasons. I think 2 things really were at

play. We specifically target in our invitations to go and brief, to hold consultation meetings, to just go and have focus groups or just one-to-one talks. We have profiled all of the local third sector organisations, for example Age Concern and others. Some have been more active in wanting to connect with us and we are still going round the loop of going back to some of those. But I think quite often in talking to some of our older residents, one of the comments I had last year was: "Well, we are here and we are old now so we are enjoying, or otherwise, the current level of services. This document is very much about getting the future right. We hope we are still around to benefit from it but we may not be", whereas I think the group that did really start to wake up to it were the people thinking: "This is going to affect me because I might need care then" or "I am the one over the next 10, 20 years of my working life who is going to have to find a way of paying for this." So I think the distribution was exactly as our Island population is distributed.

The Deputy of St. Ouen:

With regard to the Green Paper, it identified 3 scenarios and it resulted in the redesign of the care services being favoured. During the development of the Green Paper stage were any other options considered but rejected?

Chief Executive Officer:

We started at the beginning of the process, when we were working with KPMG, by saying everything is on the table. There was nothing excluded, and we did really look quite radically at should all work go off Island and we just have a sort of stabilise quickly on Island, put them on a plane or a helicopter and take them away. So there was nothing that was ruled out. Obviously as we started to have discussions with more and more people, whether it was interest groups or it was clinicians in the hospital or it was social workers or third sector organisations, some things as you start to work through you think: "That really is not practical." We have to be able to stabilise and undertake some operations on Island. If you are going to do some operations you really need an A. and E. (accident and emergency) and if you need an A. and E. you are doing theatre work, you might as well do some cold orthopaedic work, and so you end up growing a hospital. But we

started from the proposition that anything was possible and we did not rule anything out. The nature of the 3 scenarios is that by definition we felt they had to be fairly broad brush and really what one was saying was: “We could carry on as we are, because services are pretty good at the moment, people think they get good service, and they do. Let us just do more of the same.” When we looked at what that meant going forward 10, 20, 30 years it means a much bigger new hospital, it means a much more expensive model, because hospitals are expensive entities, and all the things that go with that. Also we had to keep examining could we really populate that much, much bigger hospital with doctors and nurses and other people, but that was an option. So that was one end of the spectrum. The other end of the spectrum was really simply to say: “Times are hard and the money is fixed so let us just do what we can with that” and we tried to give some indication of what that would look like and feel like. Then is there something that is in between these 2 things that is a different way of doing things that gives us a different option, perhaps provides a better range of services, a different set of choices, still expensive because we have to invest but not as expensive as the first one? There are shades of grey between the 2. You could do a bit of saving of money and redesigning, so they were not exclusive to each other but they were the broad “this one, this one or something in the middle”. I do not think there was a fourth or a fifth option that was out there that we simply said: “We will not put that on the table.” Those did seem to us to be the spectrum that we were looking at.

The Deputy of St. Ouen:

It just seems to me that when reading through the quite comprehensive document that KPMG wrote there was not a lot of time spent on perhaps other areas or matters, other options if you like, to the extremes in some of the areas that you spoke about. They all seem to have been rather focused on the 3 scenarios as described in the Green Paper.

Chief Executive Officer:

I think KPMG gave us the spectrum. There are shades of grey between. You could have had an option 1½ or 2½ but we did not feel there was a genuine alternative option from the work we did and the people we spoke to.

Assistant Minister for Health:

If I can just add to that, if I may. As part of the ministerial oversight group working with KPMG and obviously commenting on the Green Paper, there was a significant amount of discussion about all the different variables that we could have done but it really came down to: "Let us be realistic, what is achievable?" and that is where we came up with the 3 quite simple strands which are all achievable in one form or another. Certainly there was a tremendous amount of discussion in the ministerial oversight group about really the draconian option of sending everyone away, ship them off to the U.K. (United Kingdom) or France, or a full blown everything is done on Island. So all of those were covered as part of the discussion paper leading towards the Green Paper.

The Minister for Health and Social Services:

A great deal of work was done looking at everything on the table. It was not a quick fag packet, shall we say. A lot of it too has got to be awareness raising because I think beforehand people only thought of Health and Social Services as just the hospital and perhaps children's services tacked on, but I think the general public in all fairness, because until you need it you do not realise what is there, did not realise the range of community services that we do.

The Deputy of St. Peter:

If I remember correctly, we have at some point discussed a preventative model but that was considered too costly. Am I correct?

Chief Executive Officer:

A large part of New Directions was based on prevention and there is a strong theme of prevention in this document as well. One of the key workstreams is all around prevention and health promotion. As you know, we are starting with alcohol but over the 10-year period we will be examining diet, obesity,

smoking, so the whole range of lifestyle-related and preventative matters. You can be, I suppose, if you wanted to be completely focused on let us have a totally prevention orientated option, but what would you do with the people who need the care in the meantime? So we always have to balance, which is why we have a balance of a key workstream which is all about keeping people healthy and well. That is quite a mountain to climb because when you look at the questions we asked in the Green Paper, one of the questions was about how much responsibility should you take for your own health and well being and although it got a reasonable response at 73 per cent it was quite low compared to many of the other responses. For people on this Island that is a long-term project which we are committed to embarking on but it is not going to be the solution to reducing the demand that we are feeling right now and we will feel over the next 10, 20 years for hospital-based services, community-based services, care of the elderly.

Mr. M. Gleeson:

Did you discuss the matter of liaison with Guernsey and producing a Channel Island health service with KPMG?

Chief Executive Officer:

We certainly discussed the issue of sharing more things with Guernsey as part of the KPMG work and KPMG did look at the Guernsey system. The Guernsey system is very different to ours, as we have touched on before. We have a lot of discussion and a lot of joint working going on. One of things I think we have to bear in mind, we can share and I think you will see us sharing a lot more in the future. We can share appointments for clinicians, for example, and other things. We can, for some types of service, perhaps send our patients to Guernsey and they send some patients to us, and that already happens for some screening and X-ray type services at the moment. The total population of Guernsey and Jersey together is still less than 200,000 people and the general view of what a district general hospital and all of its range of services can do is it needs a population of at least 250,000 so we are still going to be on the edge of what is a safe, viable and sustainable service.

But absolutely, Guernsey is a key part of that strategy and we talk very often and develop plans with Guernsey.

[14:45]

The Deputy of St. Peter:
One thing that is notable, looking at the bibliography for the KPMG report, is that it is very much focused on N.H.S. (National Health Service) reports and ideas coming from the U.K. What work did you do to look at Europe and different models from around the world?

Director of System Redesign and Delivery:
Part of the reason that KPMG was selected to do the initial piece of work is because they are an international organisation. I know obviously because I was part of that team the number of discussions that were had with colleagues of ours and KPMG in places like Australia and in Norway - one of our partners moved to Norway. So we were linking in with the types of systems and structures and delivery of health and social care across the world. A lot of the documents that we used as part of the bibliography are themselves based on international evidence. King's Fund, Nuffield, those sorts of places, draw on international evidence and synthesise it down and use that as the basis to devise the right system. The thing that was important for us for Jersey was that it is the right system for Jersey, not just a U.K. system or an Australian system or a U.S. (United States) system that is brought here in totality. It has to be adjusted to meet the challenges and the pressures that we know we face now and we are going to face in the future.

Deputy J.A. Hilton:
I hear, I do not know whether this is correct, that France has got quite a good health system. Has any consideration been given to using the services of the French health system or looking at the way they do things?

Director of System Redesign and Delivery:

Yes. You will see with the White Paper that we talk about strategic partnerships for example and we specifically say non-Jersey. We do not say U.K. strategic partnerships because the decisions have not been made yet. It may well be that they are strategic partnerships with France or Spain or Germany or the U.K.

Deputy J.A. Hilton:
So that is an area that you are still exploring and still discussing?

Chief Executive Officer:
Yes.

The Minister for Health and Social Services:
France has got a good health system but it costs quite a lot so you have to look at where we are all coming from.

Deputy J.A. Hilton:
It is just looking at covering all sorts of different areas. The Island is talking about spending a considerable amount of money and we need to look at all the options.

Chief Executive Officer:
If I could just add very briefly, we have majored in the first 3 years, as you will be aware from the outline business cases, on really push starting the development of a broad range of community services, particularly intermediate care services. That is very much because of the growing elderly population, the need to offer choice and the need to put some release of pressure into the hospital because of the rate of patients needing to go in at the moment. So that is very much the focus, but the second phase and the third phase of our transition, which as you are aware is a 10-year transition programme, you will see within that that in the second phase particularly there will be a full acute services workstream which will be looking at all of the hospital specialties, looking at those which need change and investment within the hospital, those which will need to be the next stages of strategic

partnerships with other partners. As Rachel has said, at that point we will be looking across the board at where can we get good quality, good value for money, ease of access for patients, and where can we get a reciprocity where those providers are willing to consider bringing their services to our Island rather than necessarily us always taking our patients to them. So you will see this is a 10-year programme, we are in it for the long haul, and there is a lot of work to be done in terms of strengthening acute services.

The Deputy of St. Peter:

Just to go back on that slightly, as you said the first part is about improving community services. We have received some information from a member of the public who had experience of accessing services for an elderly parent in Brittany and apparently it is a very good model. I wondered if you had had a look at that at all in your deliberations.

The Minister for Health and Social Services:

Not specifically. I do not know whether anybody else has, whether KPMG looked at it or not. I do not know.

Chief Executive Officer:

If you look at the types of services that we are looking to put in place to support our older population in the community there are a lot of common themes. I think where they work well is more because there has been a commitment to putting those services in place and funding them rather than the ideas are fundamentally different. There has been a lot of talk in the U.K., for example, of putting more care into the community and that is starting to build up a head of steam and there is more service now but it took a little time for that to come through. Other places have very good services in the community, the Scandinavian countries. I think there are lots of models we can go and look at but they all pretty much do the same thing. It is about committing ourselves to putting it in place. We have advantages that other places do not have because we have our parish structure and we have our third sector structure which are very vibrant, very keen. A lot of the feedback

we are getting this year is coming from those third sector organisations who are really keen to work with us on the detailed planning and delivery side.

The Minister for Health and Social Services:

At the end of the day, if it works in Brittany, it works in Scandinavia or wherever, you cannot just put it in here. It has got to be right for Jersey and that is the challenge.

The Deputy of St. Ouen:

I think you are absolutely right, and I will pick up on that point, it has to be right for Jersey but equally, as you quite rightly pointed out, it is a 10-year plan. I suppose my question is what work has been undertaken to determine the overall funding required to deliver the full plan? At the moment it seems that we have got the first 3 years funding identified but there is some significant other expenditure that is not included. It is very difficult, I would suggest, for the public to determine whether they would support a particular direction if they do not know how much it is going to cost.

Chief Executive Officer:

Jason may want to say more, but what I would draw attention to is the work that KPMG did and the Green Paper itself does show you the total envelope on the back of the bailiwick model that looks at the variables, how they change, how you invest, and gives you that envelope. I think we were hopefully quite clear with the public over the totality of what a change like this over a period of time would take.

The Deputy of St. Ouen:

Can you just remind us what that is, please?

Chief Executive Officer:

It goes from £239 million to £393 million. That is the totality. Clearly what we can do, as the Health and Social Services Department, is undertake the strategic work, which we have done, and also undertake the detailed planning of how you start to give a physical expression to services for funding, which is

what we have done with the business cases to fit within the first 3-year medium-term financial planning process. The totality is something that is an issue for the Treasury to consider in terms of its longer range planning.

The Deputy of St. Ouen:

But equally it is unfair to the public to promote a particular change in direction without expressing and them fully understanding what the implications will be. At the moment I think there is a general belief that perhaps the new services can be delivered within a relatively small envelope of cost.

Chief Executive Officer:

Certainly when we were undertaking public consultation last year with the public they did understand these figures and they did ask very appropriate questions about where is this coming from. The bottom line is it can only come from all of us one way or another.

The Deputy of St. Ouen:

I come back to overall cost. We have got to determine whether or not we can afford it and whether it is appropriate. In the White Paper you talk about the service must be affordable. How do you determine what affordable is if you do not know and the public are not aware of exactly what the sort of cost is going to be and what the implications will be to themselves?

The Minister for Health and Social Services:

If you step back a bit even before whatever the options are, Health and Social Services standing still will cost us significantly more money unless we want to cut some services. We know today that there are pressures, especially within the hospital, of waiting times length and delayed discharges because there is not enough care in the community. That is the whole emphasis behind part of this White Paper of redesign. With the medium-term financial plan we have managed to do the 3 years and in the Green Paper it does give people the financial implications of 2014. We have done the outline business cases for the first 3 years so we know exactly how much it will cost going forward. That took a tremendous amount of work because there are 6 workstreams and we

have got plans for the next 3 years as well as the following year, but you can only do one step at a time. You cannot jump to the end without going through those steps.

The Deputy of St. Ouen:

No, but it is wrong to make people believe that they can have this good, super service that you are promoting within your White Paper and give them a taste of it in the first 3 years and then find that in 3 years time the funding is not available to maintain the service that you have sought to provide. So somewhere along the line there is a requirement to be upfront with the public and say, which you have started I hasten to add: "These are the challenges, this is the overall cost, but this is what you are going to get at the end of it."

Director of Finance and Information:

Perhaps I can help. In the White Paper there is a graph which is based on KPMG work which does project the costs forward over this 10-year period that the White Paper is looking at. We have tried to be very explicit about the costs and a lot of the work that KPMG did was about modelling those costs. It was based on not just experience in Jersey but international comparators, the ageing demographics, it was based on census data as well as hospital data and so on. There was a coming together of an awful lot of rich data to underpin those estimates and assumptions and forecasts about what the future looks like in terms of the finances.

The Deputy of St. Ouen:

One last question I need to ask on this spending. You speak about the figure of £239 million and I am pleased that you have mentioned it because in the White Paper it identifies a cost, a Health Department budget of £171 million and a number of other significant contributions that make it up to £239 million. Are you suggesting that the figure in the Green Paper of £393 million portrays the overall cost of the services over that period or simply the current costs with the likely addition of ...

Director of Finance and Information:

The Green Paper figures include the Health and Social Services Department spend ...

The Minister for Health and Social Services:

It is on page 19 of your Green Paper.

Director of Finance and Information:

... the Social Security spend and the other spend, which is a combination of things, so it is private spend that individuals may spend on healthcare and so on.

The Deputy of St. Ouen:

Does that figure include the long-term care provision that was agreed last year?

Director of Finance and Information:

It would include forecast expenditure for the cost of that care, yes.

Director of System Redesign and Delivery:

And the cost of that care for the increased number of people who may be eligible because they hit the over 65s and require longer term care.

The Deputy of St. Peter:

Given the assumptions that you have made and the demographics that you have looked at and the figures, do you feel that the figure that you have come up with as an overall cost, given the decreasing number of people contributing to the tax income of the Island, will be paid at an existing tax rate or will we have to be going to the Treasurer and discussing, or have you already been to the Treasurer and discussed, having to change tax rates in the future?

The Minister for Health and Social Services:

We have discussed it and the Council of Ministers, when we brought the Green Paper last time as well as the White Paper too, are aware of the challenges that lie ahead, but how it is going to be raised, whether it is taxes

or whatever, is a question for the Minister for Treasury, that we not only just spend it but we spend it on services that are needed in redesigning Health and Social Services going forward, because doing nothing is not an option. I think that is one thing in particular that we need to bring forward, that we have to do something.

Mr. M. Gleeson:

The rationale for the community services seems to be based on the need to get people out of the hospital and into community care to save money on hospital expenses and therefore it would appear to me that you have to have an early discharge policy for hospital patients. If you do not get them out of hospital quickly and into the community then this cost saving is nullified.

[15:00]

The Minister for Health and Social Services:

I think it is much wider than that, redeveloping our community services. I have just been up to Older People's Services with States Members and seen a video on *Do I Have a Choice*?, people living in their own homes being able to have a choice of being able to stay in their own homes, and I think that is important but to be able to do that because when they get to a certain age or perhaps at the end of life or needing extra support and they cannot get it from the family for one reason or another or their house is not suitable, the hospital at the moment is one of the only options. But now the emphasis is on giving that patient the choice and adding more community services in-home to be able to have that choice, because we know that there are quite a few people in nursing and residential homes who wish to be home.

Mr. M. Gleeson:

So you are not saying that the development of community care, as it were, is really a cost saving exercise? It is not based on cost saving?

Chief Executive Officer:

No, it is not based on cost saving. It is based on offering a greater range of services and choice. However, it is based on cost containment. If we were able to do these things and there were no extra patients coming through the door you would save money, but because the demography has changed and we have got more older people, the people we no longer have in the hospital will be replaced by new people coming in who need to be there. The reason scenario 3 costs less than scenario 1 is because you are doing those services in a different way which is less expensive than just having them flooding through the doors of the hospital and not perhaps being able to discharge them as quickly as you would like. So it is a cost containment strategy as opposed to a cost saving strategy.

Director of System Redesign and Delivery:

The underpinning principle for the Green Paper and the White Paper was about delivering the right care in the right place at the right time. Throughout all of this clinical safety remains paramount, so we are not talking about unnecessarily or inappropriately discharging people early that is not clinically safe. We are talking about a range of choice, improved access, avoiding the need for hospital admission where there are viable alternatives that give Islanders that choice and being able to care for people in the right place for as long as they want to be cared for in those locations.

The Deputy of St. Peter:

Are you confident of your timeframe, that your proposals, all of the elements that compose everything you need out in the community to wrap around the either refurbished or rebuilt hospital, that you can achieve it within the 10 years?

The Minister for Health and Social Services:

I hope so. Anybody got the crystal ball? We have brought it down into 3-year phases. It is important to make sure that we do that because that is a challenge in making sure that these services are going to be put in place. But, yes, I emphasise again, we have to do it. Doing nothing is not an option, so we cannot just sit back and think we have got the money or whatever. We

need to move and one of my priorities is making sure that as we go into the future services will change.

The Deputy of St. Peter:

We are quite interested in your choices relating to the 3-year stages, for example C.O.P.D. (chronic obstructive pulmonary disease) and why you decided to focus on that as a condition rather than, say, cardiovascular conditions or cancers.

Director of System Redesign and Delivery:

The prioritisation of the services that we feel need to change first or need to develop first was based on analysis and benchmarking that KPMG did, looking at international models of best practice, understanding the services that are delivered on Island now and how they are delivered and looking at the demographic changes and the impact that that will have going forwards. So it is a combination of the challenges and pressures right now and in the future. Long-term conditions, and specifically C.O.P.D. but also C.H.D. (coronary heart disease) and diabetes, have a greater prevalence in the older adult population but they also have a greater impact, both in terms of cost containment and the effective use of resources but also in terms of quality of life for patients and for their carers if those individuals are given choice. They are the reasons why those particular conditions were prioritised. It is the impact on services.

Chief Executive Officer:

We have a significant number of patients with C.O.P.D. who are regularly readmitted into the hospital who, if different types of services were available, would not be. In an ideal world, if all this money was available and I had a magic wand I would do all these things tomorrow. I would like to do C.H.D. straight away, I would like to do diabetes straight away, I would like to develop far more services in mental health, et cetera, but we do have to start somewhere because the funding always has a limit to it and our ability as the department to make change happen is limited by the resources we have, and some of that we are building and growing as well in order to be able to make

these changes as quickly as we possibly can. But C.O.P.D. had a good level of support among the clinicians in the hospital as well as an area where we really should look at getting something moving quite quickly and equally G.P.s (general practitioners) are very keen to take on board offering a broader range of services in primary care to support hospital clinicians around those long-term condition areas.

Mr. M. Gleeson:

The only thing about C.O.P.D. as it stands at the moment is you concentrate purely on C.O.P.D. and you are not including asthma or other lung conditions. I just wonder how the general public will view services purely devoted to C.O.P.D. and excluding asthma as a consideration, especially as asthma can be extremely emotionally stretching in the community where children get asthma and so on. Have you given that consideration?

Chief Executive Officer:

I think my previous answer applies again. We would like to do everything but we have had to start somewhere and that was the grouping that with the agreement of our clinical colleagues we felt was a higher priority. There is no reason why that service cannot roll out into other aspects of respiratory disease quite quickly but we have got to build up the infrastructure to do it.

Deputy J.A. Hilton:

Was C.O.P.D. chosen because of the number of hospital beds that are being taken up by people with the current condition? Was that one of the factors taken into consideration when you were choosing the services?

Chief Executive Officer:

Yes. There were lots of factors like that where you look and say: “Well, where do we start? Which one do we pick first?” and obviously you have a lot of opinion on the table, you have a lot of statistics, and you look at what seems to make sense because you do have to start somewhere.

Deputy J.A. Hilton:

We are all aware of the incidence of diabetes and it is rising quite considerably and very fast and will continue to do so in an ageing population. So I am just trying to understand why not that service. I think until recently was the service not provided down Kensington Place somewhere?

The Minister for Health and Social Services:
It was there but it was some time ago. It was moved for various reasons.

Deputy J.A. Hilton:
Basically you are saying it was a decision taken by the medical experts?

Chief Executive Officer:
We have a steering group which has a number of clinicians on it, including the 2 medical directors from the hospital, and obviously they worked with their clinical colleagues but you could start anywhere literally. It would be a great benefit for that particular area or that speciality you started with, but you have got to start somewhere and the indications were this is as good a place to start as any.

Mr. M. Gleeson:
The reason I am bringing it up is because of this question of not dealing with asthma at the same time. We are in a small community and a person with C.O.P.D. in the middle of the night in trouble will get the respiratory care team going out to them. A child with asthma who is also in the same degree of distress is not cared for by the respiratory care team. It seems illogical to me.

The Deputy of St. Peter:
If I could just add to that as well. From my understanding of our discussions just now, C.O.P.D. is something that you are seeing a high prevalence of among the ageing population now but if you think about current trends it is well known that asthma has increased dramatically among younger people recently and as this plan follows through it is the younger generations who will be the older or ageing people throughout this process. What consideration

has been given to the current trends among different age groups in preparation for issues that they are going to have?

Director of System Redesign and Delivery:

C.O.P.D. is a really good example of that because the prevalence of C.O.P.D. increases with smoking habits. So we are bearing the consequences now and will do for the next 10 or 20 years of our previous smoking habits. So again C.O.P.D. is something that is very distressing for people, for individuals and their carers. You can have a massive impact by delivering services in a different way. You can help the individual to manage their own condition and the prevalence now with the ageing population and the legacy of our smoking habits means that the incidence will probably increase going forward into the future.

The Deputy of St. Peter:

But surely fewer people are smoking nowadays and so as the 30 year-olds of today age you are not going to have such an incidence of pulmonary issues like that because they will not have had that experience of smoking to the same extent as the current ageing generation.

Chief Executive Officer:

Over the 30-year period it slides so your focus changes. Where we start now will not be where we end in 30 years time. We will have taken that on board but where we are now the issue is the older people with the smoking-related illnesses who are using our services day in and day out. Over a period of time we will expand our services and an expansion into asthma is fairly straightforward to do because the skills will be there and the team will be there that can be enhanced. Over time that team may be doing far more work with asthmatics and younger people and far less work with C.O.P.D. so it is a fact that the time changes. One of the biggest challenges for us is it is impossible for us to come to you and put on the table there is the 10-year plan, it is absolutely correct in every one of its dimensions and the money is spot on to the penny, because it will change as we go through. I think one of the most challenging aspects is being able to say to you we are pretty certain this is the

right set of things to do in the right order over this time period but things will change as we move along and you never know what is going to come in from the left field in terms of new drugs or treatments or whatever.

The Minister for Health and Social Services:
Just taking your point about smoking, we know there is a prevalence of young girls smoking and so therefore in prevention you need to target them for making sure because otherwise as the next 10 years, 30 years go they are going to have problems later on.

The Deputy of St. Ouen:
Can you just tell us who makes up the steering group that has determined the priorities?

Chief Executive Officer:
Yes. The steering group has the medical directors from the hospital, the medical director from Community and Social Services, 2 G.P.s representing the primary care community, the Treasurer of the States and then myself and Rachel and other key directors, and Richard Bell from Social Security so that we have the link into the long-term care funding work that is going on.

The Deputy of St. Ouen:
Who are the 2 clinicians?

Chief Executive Officer:
The 2 primary care clinicians are Dr. Philippa Venn and Dr. Bryony Perchard and they were nominated by the primary care body.

The Deputy of St. Ouen:
They are on the steering group. There are 2 clinicians.

Director of System Redesign and Delivery:
We have got at least 5 clinicians.

Chief Executive Officer:

We have got 5 clinicians plus our chief nurse, so all of our clinical professionals have input and we have a consultant in child and family health services.

The Deputy of St. Ouen:

Were they included in that list you just gave me?

Chief Executive Officer:

Yes. The medical director for the Community and Social Services is Dr. Carolyn Coverley, who is a child and adolescent mental health consultant. The medical directors for the hospital are Dr. Andrew Luksza and Dr. Martyn Siodlak an E.N.T. (ear, nose and throat) surgeon and respiratory medicine consultant, and the 2 G.P.s obviously are representing general practice. Then we have our chief nurse representing nursing. So all of the voices were round the table as well as obviously a smattering of people who know about finance and other things.

The Deputy of St. Ouen:

That seems to be for the most part very hospital biased.

Chief Executive Officer:

There is only 2 people from the hospital, and the hospital managing director; 3 out of about 20.

The Deputy of St. Ouen:

Twenty on the steering group?

Chief Executive Officer:

By the time you look at all of us around the table there is about 3 or 4 people from the hospital specifically, 2 people from primary care, somebody from community.

The Minister for Health and Social Services:

I think we need to provide you with that list.

The Deputy of St. Ouen:

Yes, I think so.

Chief Executive Officer:

It is in the White Paper.

The Deputy of St. Ouen:

It is just to get a sense of what input the community services and the third sector and the private sector had in looking and considering the priorities of identifying. That is great. If you can provide ...

Chief Executive Officer:

Do you want to say something about the development of the outline business case? With any steering group you have to stop somewhere otherwise the numbers just become bigger and bigger and bigger but there was a lot of work done through workshops with a much broader range of stakeholders than just members of the steering group.

The Deputy of St. Ouen:

Rather than do that, Rachel, perhaps what we could focus on is really 2 questions. First of all, we recognise the direction you are proposing the Health and Social Services Department should go in, but can you identify for us the new services that are likely or will be included in the development of this health programme and what are the existing services that you would like to see strengthened. Maybe the Minister can start.

The Minister for Health and Social Services:

That is a big question.

The Deputy of St. Ouen:

What are the new services? Quickly list the new services.

[15:15]

The Minister for Health and Social Services:
Which would you like to start with? I have not brought the big file. Has anyone brought the big file?

Director of System Redesign and Delivery:
No, it is all in my head.

The Minister for Health and Social Services:
It is all in her head. She lives it and breathes it. If you focus on early intervention which is on children on page 14 of this, you have got the maternal early childhood sustained home visiting as well as improving our professional fostering. The main aim there is to improve the early intervention for children even before they are born. It is identifying families who are at high risk to make sure that you have got the support and whatever that is needed, because as we all know early intervention is important for the families.

The Deputy of St. Ouen:
I suppose the question is do you consider that to be a new service or is it that you are just utilising current services to intervene earlier?

The Minister for Health and Social Services:
I do not know. It probably is a new service. Some of it, professional fostering we do anyhow. Well, we do fostering anyhow. It is making it much more professional, putting it on a professional footing.

Assistant Minister for Health:
Expanding and strengthening.

The Deputy of St. Peter:
I think you will find that Brighter Futures exactly provide an early intervention programme that you have just described.

The Minister for Health and Social Services:

Yes. It is enhancing that but also making sure that children are ready for school when they are 5. So some of it probably is a mix and match. You will be able to tell exactly which are the new ones.

Director of System Redesign and Delivery:

You are absolutely right. There are elements in here where small pilot schemes have been funded but they are pilot and they are time limited, so mellow parenting, for example, would be a good example of that. Brighter Futures provide mellow parenting and it is a pilot scheme. The funding is limited. We know it has a positive impact and so it would be great to be able to continue that because, as the Minister says, focus on early intervention is absolutely critical. Some of other areas are new services that we have seen from international best practice that we can adjust and make relevant to Jersey. Others are new ways of funding to encourage different behaviours, so for example rapid access to primary care for the under 5s. At the moment we know that there are a large number of people who take their children to A. and E. when perhaps they have primary care type conditions, so new ways of funding those sorts of services might encourage families to take their children to their G.P., which is where they really should be seen rather than in A. and E. There are elements around enhancing some of the services that we already have but delivering the services in a more integrated way with a wider range of choice, with greater accessibility and particularly in making sure that we can focus on some of those vulnerable and hard to reach groups that sometimes get access to services and sometimes are not able to.

The Deputy of St. Ouen:

For the most part it is a case of just building on what we currently have rather than introducing anything new?

Director of System Redesign and Delivery:

Not necessarily, no.

Chief Executive Officer:

It varies from business case to business case. Some business cases are about expanding, so you have not just got pilots any more, you have got a full range of services. In other business cases there are things which are genuinely new developments, and it is a mix of those 2 things.

The Deputy of St. Ouen:

Are you able to provide us with a list of the new services and where you are looking to expand existing services? It would certainly help us in considering the proposals put forward in the White Paper.

Chief Executive Officer:

If you would like us to prepare a list like that I am sure we could.

The Deputy of St. Ouen:

That would be great.

Deputy J.A. Hilton:

Can I just ask you a question under professional fostering. How confident are you that you are going to be able to provide for that demand in the community, bearing in mind that a very high proportion of women work in Jersey compared to other jurisdictions? Are you confident that you will get families coming forward to provide that service?

The Minister for Health and Social Services:

I hope so. A lot of work has been done and as you know will continue to be done. As you have just said about women going out to work, this is a way of being able to give a salary so women can stay at home with the foster child. From that point of view it is changing and it is a new service.

Deputy J.A. Hilton:

I note that you are planning to roll that service out in 2013. I know that you recently had an open shop somewhere ...

The Minister for Health and Social Services:

It is very useful, that shop.

Deputy J.A. Hilton:

... encouraging people to come forward with regard to adoption and fostering. Have the public been made aware or are they going to be made aware at some point in time that there will be funds in place to assist people to foster? How do you plan to do that?

The Minister for Health and Social Services:

They have very good P.R. (public relations). As you mentioned, they took a shop and they have also had a very high profile in the paper as well as going out looking for families. But I am sure if this is all approved by the States later on this year it is ready to go into action next year, because having children looked after by foster parents is so much more beneficial than putting them into one of our homes.

Deputy J.A. Hilton:

I know this question was brought up, I think last year, at a briefing about the amount of time it is taking in court for adoption cases or child hearings. Are you satisfied that the court have addressed some of the issues around the delays taking place within the court process?

The Minister for Health and Social Services:

I cannot honestly answer that one.

Deputy J.A. Hilton:

I will come back another time with that.

Assistant Minister for Health:

There is a separate piece of work going on in the Legislation Advisory Panel to do with that, which is outside of Health but the Legislation Advisory Panel are looking into that.

Deputy J.A. Hilton:

Thank you.

The Deputy of St. Peter:

A lot of the services you have been describing there involve third sector parties which of course you have already said that you have communicated with at a high level. What do you feel are their main concerns and how have you been managing that relationship and discussing your ongoing relationship without tying your hands behind your back, I guess it is? You obviously need to perhaps be able to maintain that relationship or drop it if you decide that it is not going to work.

The Minister for Health and Social Services:

That relationship is very important and at the end of the day it is all down to communication and making sure that we communicate how we see them working with us and vice versa. So having focus groups going and meeting them, which Rachel has done very well, face to face and understanding where they are coming from and them understanding where we are coming from is vitally important. We have got another meeting, I think, lined up. We had another meeting about 2 or 3 months ago of all the different Association of Jersey Charities health-associated charities and it was very good. It was very much a 2-way thing, but also with the subgroup that they have set up within themselves of the Association of Jersey Charities with the money that they have had from the Minister for Treasury to get a co-ordinator they were able to update their colleagues of the next step for them. That is very beneficial.

The Deputy of St. Peter:

Do you see that new appointment as the key person who will perhaps help to negotiate service level agreements between yourselves and the providers?

Chief Executive Officer:

I would not have thought so. I think that is someone who is very much there to help support the third sector in terms of how they want to develop themselves. I think one of the things that we have found with third sector organisations, and I think it is perfectly reasonable that they would be this

way, is all of the organisations are different. Some very much see themselves as wanting to continue being advocates and supporters to their client group and quite often what they want is to lobby and be advocates. Other groups see themselves as moving into the arena of providing services. So I think it will be different depending on which voluntary sector group we are working with. It may well be that their development officer helps to develop training for third sector organisations that want to become providers, who may have to engage in some elements of negotiation around contracts, service level agreements, whatever, but I would not see them as necessarily being the person who did that negotiation for them.

Assistant Minister for Health:

I think the strength is going to come from the fact there is one person overseeing the third sector, effectively, and looking for symbiotic relationships between different groups who are heading in the same general direction but do not actually touch. I think there is great advantages of bringing them together to enhance the delivery of the particular cause that both are chasing and I think the great strength is going to come from improved services from more co-ordination within the third sector itself.

Director of System Redesign and Delivery:

Some of the third sector organisations are already identifying that themselves and saying: "We do not want to compete with other third sector organisations. We are effectively the same service delivery. Let us work together on this." For me from the third sector perspective there have been 3 important messages. The first one is in terms of listening to them and we have involved a large number of third sector organisations as we produced the outline business cases. The second thing I think is in terms of having an open dialogue and being clear that we cannot always meet every organisation's expectations all of the time because a lot of these organisations are very deep single issue organisations. We need to listen to them and understand where they are coming from. The third thing is about their capacity as organisations in terms of the opportunities. A number of them, as Julie said, are very excited about the types of opportunities that might be available through the

White Paper and through us working jointly with them but are concerned to make sure that they are ready to take advantage of these opportunities now. I think that is another area where the exec officer will be able to help them, will be able to upskill them and be able to help them to understand how to take advantage of opportunities and how to work in partnership. At the moment it is quite new for them.

The Minister for Health and Social Services:

I think it is fair to say they themselves have come a long way, that they have now formed as a group because before they were very singular. To try to get a list of Association of Jersey Charities, especially the health-orientated ones, there was not one source. You had to go down the actual website and find out what they did, whether they are health-orientated or not. So they themselves are very much coming into a body, which is very good.

The Deputy of St. Peter:

What about those service level agreements on an ongoing basis? Once you have entered into an arrangement with a provider how do you give them a surety that you are going to require their services on an ongoing basis? I believe at the moment your service level agreements with third sector providers are on an annual basis only.

Chief Executive Officer:

It depends on the type of service and it depends on the nature of the organisation. To some extent it depends on the size of the agreement. Obviously the larger the agreement the more you want to give certainty over a period of time and therefore I would expect us to start negotiating service level agreements that certainly extended beyond one year, perhaps to 3 years or even longer in some cases. Where I think the sums of money are small or perhaps we are just testing something out for a time you would probably want to keep that more limited because obviously if it does not work you would one day want to do something else. So I think it will vary according to the nature of the service and the type of organisation.

Deputy J.A. Hilton:

Can I ask you a question with regard to providing care through the G.P.s. What discussions have you had with the G.P.s on enhancing the services that they provide? Obviously that is an important part of your White Paper. What discussions have you had? Where are you with that? You will be having service level agreements with them, presumably, to provide certain services. How close are you to doing something?

Chief Executive Officer:

It is. G.P.s and their representatives, particularly through the primary care body, have been heavily involved right from the beginning of this piece of work. If you were to ask me are all 93 G.P.s signed up to it, no, of course not, but the vast majority of them are well briefed and sighted on this work and they are largely supportive of this direction of travel. However, being able to do this with primary care will mean a significant change to the way primary care is remunerated and delivered, because at the moment it is a cost per item service that is delivered through the G.P. That does not lend itself to the types of services that we set out in this document. In the main they would like to move away from that way of working. They would like to move more into a contractual arrangement where there is clarity about funding upfront, there is less need to charge for everything, there is less need for the G.P.s themselves to be doing everything so they can have more of a mix of staff within their surgeries and that opens up their time to take on board more of the long-term conditions management, working with the clinicians in the hospital. So in the main they are very subscribed and signed up to that direction of travel. The devil is how do you get from where we are now to something which is probably a contractual relationship. There are some elements, for example the C.O.P.D. part of the long-term conditions, we would need to have a specific agreement with the practices and we would have to fund that through whatever money we ultimately, hopefully, are granted by the States when that debate happens later this year, but that is only C.O.P.D. What ultimately you would like to get to, I think we should get to and this is part of the debate that is around the primary care workstream, is contracts for

services with all practices which would remove some of the need for all these individual payments and benefits.

[15:30]

That is a big piece of work. Designing a contract that works for Jersey, works for Jersey G.P.s, works for Jersey residents and is good value for money and has none of the perversities of, for example, the English contract system will take some real work, which is why there is not a lot of change in primary care. There is some but not the whole totality of it in the first 3 years because quite frankly we could not deliver it in the first 3 years. It will be a big push in the second 3-year period.

Deputy J.A. Hilton:
So in a perfect world you would like to be able to see the G.P.s delivering some of those services in the sort of middle sector of your delivery plan? That is where you see yourself going?

Chief Executive Officer:
Yes.

Deputy J.A. Hilton:
Are you confident on the basis of the discussions that you have had with them or with their representatives that you will get there?

Chief Executive Officer:
Yes. I think the majority of G.P.s are interested and excited by that prospect but they are concerned, as you would expect, of how do you get there. You are changing the model considerably so they will have issues about their remuneration and how they pay for premises and all those sorts of things, which will all have to be worked through to safeguard the interests of the public and the taxpayer and also to give them a reasonable remuneration for what we want them to do.

Deputy J.A. Hilton:

Do you have somebody in the department dedicated to progressing that piece of work?

Chief Executive Officer:

We are currently building that team. You will recall that we are currently developing a quality contract for G.P.s which is an agreement we have with the G.P.s that they want that and it is part of changing from the current benefit that is paid with the additional £4 top-up which was to get them prepared for revalidation and appraisal and all those things. That money will slide into a quality pot and they have agreed that we and they will work up, with Social Security, a quality contract which will have things within it which are deemed to be markers of good quality practice and if they can demonstrate those things they will get that sum of money from the quality pot. That is a good way of us putting the toe in the water with them of what does it feel like to have a contract arrangement rather than an item for service type arrangement. We are building a small team, which was part of the proposition that was approved by the States, to help us manage that primary care relationship, set up a performers list, validate, manage poor performance where it exists - which fortunately on the Island is not widespread, it is odd occasions - but also to push this quality contract idea. By having that small team we can start to use that team to develop a longer term piece of work which will transform the primary care system, but we have to do that with the agreement and input of G.P.s otherwise it will not work.

Mr. M. Gleeson:

On page 21 of the White Paper there is a paragraph, second tick down, that says: “The services of a consultant physician, working in the community.” Do you intend to employ a community geriatrician and reinstate the old and very useful concept of domiciliary consultations over care of the sick elderly and the rights or wrongs of getting the patient into hospital or not getting them into the hospital and so on? Is this going to be a way of developing a liaison with the G.P.s to enhance the efficiency of the community services that are going to be funded?

Director of System Redesign and Delivery:

One of the main tenets of community services is going to be the multi-disciplinary team that needs to incorporate not just clinical input but also a whole range of other input, so nursing, for example, some pulmonary rehab, the whole range of services that are needed to ensure that Islanders, where they choose to, can be looked after in their own home. In terms of the specific question, the tick down here, this is initially a consultant physician who we have working with us at the moment, a respiratory physician, whose role will be to work very closely with G.P.s to make sure that awareness is raised, to make sure that skills and tools are transferred, to make sure that the way that the service is designed and developed is done with G.P.s as well as with the community multi-disciplinary team, and to make sure that those Islanders that need to be and want to be maintained in their own homes initially can be.

Mr. M. Gleeson:

So in terms of a community geriatrician this is not a community geriatrician?

Director of System Redesign and Delivery:

No, it is a consultant physician.

Mr. M. Gleeson:

But is that a locum? Is that a temporary ...

Director of System Redesign and Delivery:

It is not a locum, no. It is an existing member of staff who is going to be working for a fixed period of time initially to get the service up and running, working very closely with the G.P.s.

Chief Executive Officer:

I think we are talking at cross-purposes. I think that is very specifically around the C.O.P.D. project.

Director of System Redesign and Delivery:

Yes, that is right but the overall is a team.

Chief Executive Officer:
But the overall project is to develop a role of a consultant who is community based and whose focus is on ...

Mr. M. Gleeson:
So you are going to appoint a community geriatrician? That is really what I am driving at.

Chief Executive Officer:
Yes.

Director of System Redesign and Delivery:
It will be a physician that is working within the multi-disciplinary team.

Mr. M. Gleeson:
The concept of domiciliary consultation where a consultant visits the patients in their homes, assesses them and advises the G.P. on their management and/or their admission to hospital or other forms of management has been lost in current practice largely. We do not have any domiciliary consultations going on any more, which I think is a pity and I think it would be helpful if it were reintroduced.

Director of System Redesign and Delivery:
I think it is important to make sure that individuals can be assessed and cared for in the most appropriate location, whether that is within their local G.P. surgery, whether it is within their own home, and of course it is not just for things like lung disease, it is also for conditions like dementia. We need to make sure that individuals have the right assessment in the right location and then have the right ongoing management and care and are supported to increase their confidence, for their carers to increase their confidence so that they can look after themselves and understand what is happening to them and

how best to care for themselves. It is a true partnership with the G.P., with the multi-disciplinary team and with the individual and their carer.

Mr. M. Gleeson:

When do you see this appointment that seems to be an important appointment to try and advance the concept of community care and get the G.P.s involved? Bringing them into discussions over their own patients I think would be very helpful.

Director of System Redesign and Delivery:

Absolutely. The particular consultant physician role that we have specifically noted in here is very early in 2013 in absolute recognition of the fact that we need to really get on with this and we need to start working very closely with G.P.s and with that particular cohort of individuals to make sure that we can deliver those services as quickly as possible.

Mr. M. Gleeson:

On the point of the consultant physician, do you envisage this being an easily achieved appointment? Are there lots of these rather unusual individuals available and trained and doing the work out in the health service? I am asking that because I am not aware.

Chief Executive Officer:

I think in the U.K. they have moved back into developing consultants who largely are community based and work in community settings. Certainly I know of places I have worked in the U.K. where that type of role was being developed. Like all recruitment to the Island, it is something you have to work very hard to make sure you attract people and that you can give them the support they need to move over here.

Mr. M. Gleeson:

He could almost be a crucial individual in helping you develop this service and also with his knowledge in recruiting nursing staff and so on.

Director of System Redesign and Delivery:

Yes, and that is really important. What I was just about to say was that it is a really good example of where we would hope to work in partnership with the third sector and with parishes because our third sector partners already have respiratory specialists, for example, who we would be wanting to work with us as we develop the detail of how the services will be delivered going forward.

Mr. M. Gleeson:

Where does that leave our local respiratory physician in the scheme of things? You have got the consultant geriatrician or community geriatrician and our respiralogist introducing the respiratory service. He is not going to be doing the role that you envisage for the consultant geriatrician or community geriatrician.

Director of System Redesign and Delivery:

Do you mean initially or going forwards?

Mr. M. Gleeson:

Yes. You said you are going to appoint this physician in early 2013 but at the same time you have got a member of staff working to develop the respiralogy service, working through that. He is in a separate development, is he?

Director of System Redesign and Delivery:

No, not necessarily. What we need to make sure that we do with these services, as well as with all of the other services in the White Paper, is draw on the experienced teams, the experienced staff members that we have at the moment, because I think only by doing that can we make sure that the services are right for Jersey. We may, for example, be looking at backfill arrangements for staff that we already have working within the service who are best placed because they know the individuals, the systems, the G.P.s. It would be easier and more appropriate in some cases for individuals who are already working with us to develop these services with us and for their substantive roles to be backfilled, for example.

Mr. M. Gleeson:

I am not quite clear now what is going to happen.

Chief Executive Officer:

Is this something we can perhaps talk about in more detail in another place? There is a lot of information contained within these outline business case areas that we could go into. We would be very happy to spend more time on this if it would helpful.

Director of System Redesign and Delivery:

I do not want to get into individual cases and individual staff members. That is probably not very helpful.

The Deputy of St. Peter:

Okay, fine. If we move on and talk more generally about the training that you see is required to move people from the location based in work that they have been accustomed to to going out and working within the community. I think we have become aware that a number of community nurses were employed in the U.K. but subsequently as a sort of cost-cutting measure many of them have been made unemployed or their jobs are definitely hanging in the balance at the moment. How do you expect to draw on that experience across the water and perhaps take on board some of the skills that those people have learned and transpose them into our changing workplace here in terms of community provision? Do you think there will be a lot of training required?

Director of System Redesign and Delivery:

As hopefully will be clear from the outline business cases that you have seen, we will need to look to develop those services in community settings. We know that we have challenges at the moment in terms of recruitment and retention, particularly in certain staffing groups. We want to make sure that this is appropriate, the right type of staff makes the right type of skill mix, but also that it supports Islanders. So there will be a mixture of growing our own, for want of a better terminology, training our own, and of course that has

beneficial impacts if you are looking at things like healthcare assistants, of which we know we will need quite a large number. That can help us with the unemployment situation and retraining is needed for that. But also bringing in skills not just from the U.K., elsewhere in Europe, elsewhere internationally, to help to enhance that so that we have got a blended mix of growing our own and bringing in others with those specific skill sets to work jointly in a team. The ultimate in this is it needs to be sustainable going forwards for Jersey and appropriate for Jersey.

The Deputy of St. Peter:

Very much particularly for nursing in terms of nurses, that you have a lot of work to do to maintain the base that you have I understand.

Chief Executive Officer:

Yes. It is certainly true that there can be a lot of interest in our vacancies, particularly because of all the changes that are happening elsewhere in the U.K. at the moment. But the fact of the matter is it can be very hard to convert that interest into appointments that come over here, take the posts and then stay. A lot of that is to do with affordability, employment opportunities for partners, access to affordable housing and those sorts of things. So clearly within the States if we do take this forward there will have to be a lot of working across departments to ensure that we have got the right packages available to ensure that we can attract those nurses who would like to come and work here as well. As well doing all the things that Rachel has already spoken about in terms of growing our own and developing our own abilities in nursing, we will always need to attract specialist nurses.

The Minister for Health and Social Services:

What this diagram really shows is it is a multi-disciplinary team and one area is the pharmacists. We know we have got good pharmacists over here and it is helping them use their skills and their full potential because they too have a part to play. So it is not just nurses and healthcare assistants, it is the wider disciplinary approach.

[15:45]

The Deputy of St. Ouen:

One of the matters, Minister, that I would like to speak about for a moment is to do with the significant risk with regard to delivering the new proposals. Just staying on staff for a minute, in the White Paper you clearly state you have difficulties associated with recruiting staff. We know there are a considerable number of vacancies and we know that we have not got the correct complement of staff available for the service we currently provide. However, in the White Paper you say that not only are we going to be wanting to meet the current need but we are also wanting to expand other services. I suppose I am asking you what guarantees or assurances can you give us, and indeed the public, that you are going to be able to meet these additional needs of staffing if indeed now you are struggling to recruit and have been for some time.

The Minister for Health and Social Services:

I think it is a challenge and will continue to be a challenge, especially with the nursing staff but then just mention what I have just said about a multidisciplinary. It is a challenge there of trained nurses too but there is healthcare assistants and we know that we can look on Island for those providing we give them the proper training, et cetera. But if we look on the government side of it, we very much acknowledge that it is going to be a challenge and there is a workforce stream which goes right across all the different O.B.C.s(?) to make sure that we can look at getting the qualified staff that we do need.

The Deputy of St. Ouen:

But key to delivering the services will be people ultimately who are able to provide the services that you have highlighted in your plan.

The Minister for Health and Social Services:

Yes.

The Deputy of St. Ouen:

What efforts are being made now today to deal with and address those issues so that we can have some confidence as we move forward that indeed the people will be there to serve the population as you describe?

Assistant Minister for Health:

I think it would be useful to mention at this point the work that is being done by your department and they are introducing the nursing assistants courses and they are doing the training from Island staff there to support particularly the third sector and private sector service providers to deliver the White Paper objectives. That is the work that has been going on across departments now as we try to improve. But you are right, James, it is a challenge. It is a challenge throughout Europe. It is not a Jersey problem. It is a problem across Europe in the training and keeping of nurses. We just keep trying to manoeuvre into a relevant position to attract or try to grow our own.

Chief Executive Officer:

I think this is rather like the previous question about funding. We can develop what we think is a sustainable way of moving forward to create a good range of services on the Island. How it gets funded and whether issues of attracting nurses because of packages and making those packages attractive is an issue for politicians. We have brought forward suggestions and proposals. One of the things that I think will face States politicians later this year when you get the White Paper lodged is to recognise it is all these other things which will also have to be tackled if this is going to become a reality. What we do know …

The Deputy of St. Ouen:

Which is why I asked the Minister, because indeed she is the Minister and the politician, whether or not she is able to give assurances to the public, and indeed other politicians, that we are not heading off and raising expectations that we are not able to deliver upon and without those assurances, without that confidence, it is very difficult to ultimately make the right decisions to indeed provide the services which you would like to deliver. We are mindful of

the fact that, Minister, we are looking and we will be looking for those assurances throughout the review that we can confidently go to the public and confirm that, yes, these proposals are appropriate; yes, they can be delivered; yes, there is a cost; yes, we can afford it; and yes, they are in the best interests of the community.

Assistant Minister for Health:
Thank you.

The Deputy of St. Ouen:
I presume you would all agree. I presume that is what you would like to see happen and that is why we ask the questions that we do.

Director of System Redesign and Delivery:
One of the things just to add on to it is as we produced the outline business cases, and indeed all the plans that underpin those, we went through quite a rigorous process to do that. We engaged with a whole wide range of individuals and organisations, whether it is third sector, parishes, politicians and different staffing groups, and we challenged and challenged and challenged because we did not want these plans to be our ideas sitting in a room developing something that sounded great but was never going to be deliverable for Jersey. We have really pushed people quite hard to make sure that, as far as possible, the plans that we have put in the White Paper and the outline business cases that underpin it are achievable and they are appropriate and they are deliverable.

The Deputy of St. Ouen:
So you are confident that the third sector and private sector service providers on the Island are able to meet the new demands that will be placed on them that flow from this new plan?

Director of System Redesign and Delivery:
I think I would call them opportunities rather than demands and as we talked about earlier on, a number of third sector organisations are really quite excited

and they are saying to us: "When can we get on with writing the full business cases with you? When can we do the detail? People are pushing to get to that next level of detail with us. There is a huge amount of ambition and excitement out there about the plans that are contained within it.

The Deputy of St. Ouen:

But if we were to speak to Family Nursing, for argument's sake, and ask them how confident they are that they will be able to deliver the 24/7 care that you speak about in this document, the response would be: "Absolutely, we see it as a great opportunity. We have no problem in meeting that expectation and need." Is that what we would hear?

Director of System Redesign and Delivery:

What you would probably hear, I think, is: "We want even more clarity on exactly what is required" and our response to that is: "Absolutely and we will be developing that with you as we go forward this year." It is a good example though because they are already providing some 24/7 end of life care and we have made some more money available for them in 2012 for them to expand that 24/7 end of life care. They were really pleased that we did that and we were really pleased to be able to do that as one of our priorities.

The Minister for Health and Social Services:

It is good to have that money so we can, as you said, pilot it and see what works, what needs to be changed or whatever as we progress in the next 3 years or so, but it will be a challenge and will continue to be a challenge. But a lot of it is not just within Health and Social Services but like the cost of housing, the cost of childcare, the cost of some nurses' posts. The States Employment Board have done a lot of work with the Nurses Union and with Health about aligning their pay to allied health professionals and we are going back to the States Employment Board next week or so. So a lot of work is being done but it is going to be a challenge.

The Deputy of St. Peter:

I think it will come down to the views of the 48 other politicians who are not members of the Health and Social Services Department to agree with you and give you support.

The Minister for Health and Social Services:
But some of those challenges are out of our control. We have nurses who mostly now are in their 30s or whatever and they are mostly women who bring their families over here, so it is the cost of childcare but also their partner is looking for work but they cannot get work so therefore they cannot afford to stay here because their partner has not got work. They cannot afford it if they have got a house in the U.K. and they have not been able to let it. That is another issue that they cannot afford to stay so they have to say: "Well, we have to go back to the U.K."

The Deputy of St. Peter:
Do you have a question?

Deputy J.A. Hilton:
I do have a question. It is slightly off that subject though. I have had a look through the outline business cases and if you are successful in the Council of Ministers accepting those and they go forward in the 3-year financial plan, am I right in saying that from what I can tell there will not be any additional cost to the user of those services and those outline business cases services? Are there any user pays charges in the math?

The Minister for Health and Social Services:
No.

Deputy J.A. Hilton:
The reason I bring that up is because I noticed it a couple of weeks ago when I was reading this. I have just found it and it is an outline business case to do with providing the early intervention. I may have misunderstood but it talks about increased midwifery and primary care and a possible cost to the mother

of approximately £100 to deliver that care in terms of services in the community.

Director of System Redesign and Delivery:
I think that is at the moment, is it not?

Deputy J.A. Hilton:
I do not know. Could you clarify that for me?

Chief Executive Officer:
No, there is a pilot running at the moment between the midwifery department at the hospital and a small number of practices to bring community midwives out into their practice but at the moment, because of the way the system works, to see that service in the practice there is a charge. What we would be looking to do is create that service in primary care without there being a charge.

Deputy J.A. Hilton:
Okay, I just wanted you to clarify that.

Chief Executive Officer:
I think that is right.

Director of System Redesign and Delivery:
Yes so this section here, that is the sensitivity analysis, is to reflect that we did not just go with one model. We looked at the model and said: "What if we did this? What would the impact be?" and that £100 is what has been charged currently.

Deputy J.A. Hilton:
That is now, but hopefully when these are accepted there will not be any user pays charges attached to any of the services that you are going to be delivering?

Chief Executive Officer:

No because the worry we would have is if there was a user pays charge, those expectant mums who really needed to be getting careful monitoring would not be engaging with the service.

Deputy J.A. Hilton:

No, absolutely. That is why I just wanted to clarify that with you.

Chief Executive Officer:

No, it is just part of the alternative consideration before you get to the end point.

Deputy J.A. Hilton:

Okay, thank you.

The Deputy of St. Peter:

I think just to round up, one final question from me is are you still confident in delivering this change if it is agreed by the States Assembly in October? Are you still confident that you will be able to stick to a timetable in delivering this great range, great as in vast number of services?

The Minister for Health and Social Services:

I am very aware that whatever I say it could come back to me and bite me but, yes, I think so because, as I said, change, we have to do something. We cannot stand still and do nothing is not an option but I will caveat that and say you never know what is going to happen in the next 2 or 3 years which could slide us offline but that is my own … we have done a lot of work on this and it is important that we do put this in place for all Islanders. So a caveated, yes, I suppose.

Chief Executive Officer:

There is no lack of commitment in the department. People really do want to do this because we need to do it for Islanders. We have a small team. It has grown a bit over the last couple of years. We will, by the end of 2013, have

delivered over £7 million worth of savings to C.S.R. (Comprehensive Spending Review). That had to be done in that timeframe. I therefore think we can probably spend £7 million on developing these ranges of services in that same timeframe but we need to get on with it.

The Minister for Health and Social Services:

I think one good point you just mentioned there is about the staff, that we have engaged with frontline staff by having a lot of stakeholders' days, kind of focus groups, offering cake and coffee, and they have really been engaged in it and having gone through 2 or 3 they are really up for it. They are really excited and can really see how their service will change and having thought of going down this way as well, this way, they are really up for it and even went to St. Saviour's Hospital Rosewood a couple of weeks ago and the first thing they said was: "Good you have brought some papers. We are so encouraged by this. It is so exciting." It was really good, really encouraging to see.

Director of Finance and Information:

I think the other thing is the level of planning and thought that has gone into this is huge. You have seen the outline business cases. The next stage is to do full business cases, which we will plan out in more detail. It is a properly thought through, planned out process, which is what I think enables us to be able to say with confidence that we know it can be done.

Deputy J.A. Hilton:

I have just one final question. You may have answered this previously but I cannot recall that. With regard to the feasibility study on the new or refurbished hospital, what population figure are you working on?

The Minister for Health and Social Services:

The new census figure.

Deputy J.A. Hilton:

So then there is no additional capacity there? It is 100,000?

Chief Executive Officer:

No, that is the baseline figure we are working on and then it will be projected forward across the time period and then what will happen is we will factor in developing scenario 3, which is all these business cases and others. What does that do to the flow of patients and the types of services? That is a piece of work that we are working on at the moment.

Deputy J.A. Hilton:

So you are working on that 100,000 figure?

Chief Executive Officer:

As the baseline.

Deputy J.A. Hilton:

As a baseline.

Director of Finance and Information:

The consultants that are doing the pre-feasibility study are working with the work that we did with KPMG and also the Stats Office wanted to make sure they have got the most up-to-date census data and projections going forward.

Deputy J.A. Hilton:

Thank you.

The Deputy of St. Peter:

Thank you. Well, we look forward to meeting you again in September. I think you are going to discuss the consultations for the White Paper.

The Deputy of St. Ouen:

As well as the outcomes.

Chief Executive Officer:

Can I just say we were very pleased to have the opportunity to meet with Professor Whistler on the Friday and obviously anything that we can do to

support either of your expert advisers in terms of having briefings offline going through some of the detail we would be very happy to do.

The Deputy of St. Peter:

Thank you very much. That is much appreciated. Thank you. We will close the meeting.

[16:00]